Medicine and Money

Academic health centers: a future of struggles and new identities

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Summary points

- Academic health centers are creating partnerships with health systems in response to their financial crises.
- These partnerships lead to cultural shifts at academic health centers and increase fiscal awareness and accountability for education, research, and patient care.
- In the future, more academic health centers are likely to develop partnerships, which may lead to a fundamental redefinition of their missions and identities.
- Transformation will involve creating a new social vision and role for academic health centers in the changing healthcare system.

Last year, the University of Pennsylvania's health services system lost nearly $90 million. Georgetown University Medical Center has lost almost $120 million in the past two years. Even after sharp cost-cutting, Brigham and Women's Hospital in Boston, a chief training ground for Harvard Medical School, lost $15 million in the first quarter of this year.[1]

Academic health centers have been among the nation's most successful institutions, making headlines for advancing scientific knowledge, developing and providing dramatic new forms of patient care, and training an ever-increasing cohort of new health professionals.[2] But they now experience challenges that have put their traditional missions in some jeopardy,[3] challenges that include decreased government support for operations and research, more managed and cost-conscious healthcare reimbursements, and increased competition from medical practices, hospitals, and nonuniversity research operations.[4]

The losses cited above were all reported in the Chronicle of Higher Education, demonstrating that academic health centers and their financial crises are in the headlines. Many blame the financial situation on inadequate institutional responses to changes in healthcare delivery and education. One response of academic health centers has been to redefine traditional relationships with the care delivery system by negotiating partnerships with health systems, both for profit and not for profit, that offer a range of services and a more secure fiscal base. Academic health centers have negotiated "partnerships" such as buyouts, mergers, affiliations, and lease agreements. The arrangements are as varied as the academic health centers themselves. Their structure is influenced by such forces as managed care penetration and market competition (including competition from other academic health centers nearby); fallout from the 1997 Balanced Budget Amendment; and the unique features of each academic health center, including institutional history, culture, and key individuals in leadership positions.

The Center for the Health Professions at the University of California, San Francisco, conducted an exploratory study of three academic health centers in 1998 to examine the impact of such partnerships on teaching and research missions. The stories of two of them, the Allegheny University of the Health Sciences in Philadelphia and the University of Minnesota in Minneapolis, offer contrasting scenarios of how things have changed and lessons in how the future might unfold. These stories underscore the dramatic issues that arise when different cultures merge and a new market-based approach to healthcare delivery, research, and education is adopted. Together, the stories suggest a pressing need for a new social vision of the nation's academic health centers.

Allegheny University of the Health Sciences

Allegheny University of the Health Sciences began to take shape in 1987, when Allegheny General Hospital in Pittsburgh, Pennsylvania, acquired the financially struggling Medical College of Pennsylvania. The medical school needed a fiscal partner to survive in a marketplace with excess bed capacity, declining reimbursements, and fierce competition from local academic health centers. The hospital, in turn, was looking to enhance its academic and research cachet and, ultimately, its competitive edge. Less than a decade later, the Medical College of Pennsylvania was part of a conglomerate run by the Allegheny Health, Education and Research Foundation (AHERF), which by then had acquired another Philadelphia medical school, namely Hahnemann University, a health professions school, amounting to the largest network of hospitals and health systems in the state. Allegheny University of the Health Sciences, itself owned by the private, not-for-profit AHERF system, housed Medical College of Pennsylvania/Hahnemann, one of the largest medical schools in the country, and sponsored a range of other health professions education programs.

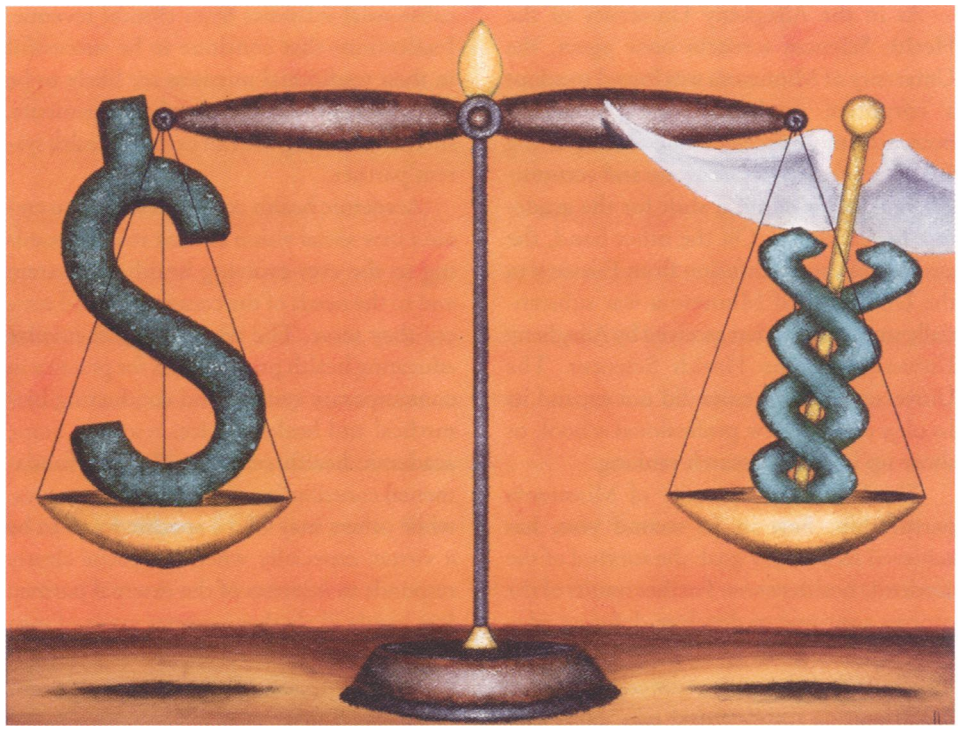
AHERF's acquisition of the medical schools, their respective university hospitals, and subsequently, several affiliated hospitals in the region, was motivated by its desire to increase access to tertiary care, research dollars, and prestige, and to establish a statewide integrated network of healthcare delivery. AHERF brought its corporate archetype to bear on how education and research were structured within the academic health center. Departments became independent business units, while faculty practices, previously managed by individual departments, were merged to achieve economies of scale, control, and bargaining strength in numbers. Allegheny University of the Health Sciences profited from an infusion of money, which

was used to expand the faculty, to fund research (leading to a dramatic rise in the university's NIH ranking), and to create a new school of public health.

In expanding its network, AHERF found itself having to acquire hospitals that were part of larger systems. For example, in acquiring St. Christopher's Hospital for Children in Philadelphia, to ensure access to pediatric specialty care, AHERF was encumbered with three struggling affiliated community hospitals. After several years of expansion, fueled by aggressive infusion of capital, a number of forces converged to strain AHERF's burgeoning system. By 1997 the system was losing nearly $1 million a day. Measures to cut costs were instituted to stem the rising tide of red ink, but they provided too little relief too late. In 1998 the newly chartered Allegheny University of the Health Sciences, its medical school, and affiliated Philadelphia hospitals were in the midst of bankruptcy proceedings.

AHERF's problems went much deeper than declining reimbursements and the growing impact of cost-conscious, managed-care insurance plans. Forty million dollars in new faculty costs had been incurred in less than three years, and a system still driven by the need to fill hospital beds was struggling with an occupancy rate of 60%. Other contributing factors included mismanagement at the top levels of the organization, uncontrolled desire to grow at any cost, and financial misconduct. According to a report in the Association of American Medical Colleges Short, Topical, and Timely News, on 28 June 1999, Allegheny's creditors filed suit, seeking more than $1 billion in damages, against the Allegheny Health Education and Research Foundation, five former AHERF officers and directors, and five current officers and directors of Allegheny University Hospitals-West. The creditors reserve the right to add additional defendants as the case proceeds. Among other things, creditors accused AHERF officials of lax oversight and failure to implement cost controls.[5]

Tenet Healthcare Corporation has purchased eight of AHERF's Philadelphia hospitals, the faculty practices, medical schools, and Allegheny University of the Health Sciences for $345 million. Tenet has agreed to provide $33 million in each of the next three years for administration, supervision, and teaching provided by the AHC faculty to the hospitals. Drexel University has agreed to take over management of Allegheny University of the Health Sciences, and officials are optimistic that this outcome will preserve the educational, research, and service programs of the institution.[6]



AP Photo/ Carl D. Walsh

It can be hard to balance health care and cost.

University of Minnesota

The University of Minnesota's academic health center, one of two in the state and the only one that is publicly funded, consists of six professional schools, which train nearly 80% of the state's health professionals. Minnesota, where managed care took root, is known for its highly competitive healthcare environment and consolidated integrated delivery organizations. In the early 1990s, the University of Minnesota began to experience increasing financial hardship, caused by a shift of care to ambulatory settings and by the health center's competitive disadvantage in managed-care contracts, due to the higher costs of providing care associated with teaching and research. In 1997, the hospital posted a deficit of $20 million, owing to a decline in both patients and revenue. It was projected to have a deficit of $100 million by 1999.

Faced with either closing or selling the hospital, the University of Minnesota looked for a partner to provide financial solvency, to support its academic programs, and to guarantee continued service delivery. In 1997 the academic health center sold its hospital, affiliated outpatient clinics, and parking sites to Fairview—a private, not-for-profit health system—for $87 million. Fairview expanded its capacity for tertiary and quaternary care and agreed to provide resources to support education and research, as well as opportunities for outreach education and research, throughout the system. The agreement allowed the academic health center and Fairview to function collaboratively while retaining their respective autonomy, authority, and governance.

As in the Allegheny University of the Health Sciences scenario, Fairview established a new payment and accounting system and pushed the health center to improve its accounting of and accountability for the costs associated with education, research, and patient care. In the process, the University of Minnesota agreed to reduce the annual subsidy it drew from the hospital, dropping from $53 million to $12 million.

As in the Allegheny University of the Health Sciences scenario once again, the University of Minnesota was forced to adopt a corporate model of doing business, becoming more fiscally aware and expecting faculty to become more aware and accountable—a major cultural shift for the academic health center. On the other hand, the amount of capital infusion from Fairview to the University of Minnesota was substantially smaller than that received by Allegheny University of the Health Sciences. The University of Minnesota did not expand its faculty, create a new professional school, or shore up its NIH research ranking.

The Fairview-University of Minnesota partnership, now in its second year, has achieved its primary goal: the survival of the academic health center. Further results of the process continue to develop: defining education and research costs, integrating clinical efforts across two very different systems, incorporating training and education into the new system, and adapting to the challenges of merging cultures and priorities.

New identities in the future

Having lost their position at the pinnacle of the healthcare system,[7] academic health centers are struggling for their identity. As these two examples show, academic health centers must become more accountable for determining and supporting the costs of education and research without relying on substantial subsidies from clinical revenue. Institutions that continue to be successful in their traditional missions are likely to be faced with developing novel arrangements, such as affiliating with an external health system partner.

Academic health centers also need to create a new social vision of their role, responding to the ever-evolving healthcare system and to the needs of the community and society they serve. The new role must involve educating health professionals for practice in contemporary systems and conducting biomedical and health services research. Some academic health centers will make fundamental contributions in more than one area, while others may find a specific focus to be a virtue, especially when the focus clearly responds to interests of the external partner. It is highly likely that a greater range of missions and greater institutional distinctiveness will be a hallmark of academic health centers in the future.

The capacity of academic health centers to sustain a trifold mission—to teach, conduct research, and provide clinical care—has depended on revenue from fee-for-service and uncapped Medicare reimbursements and on the ability to cross-subsidize activities. Without strict accountability, large institutions have been built and are now faced with the difficulty of sustaining multiple missions in a very cost-conscious environment.

A number of questions are increasingly being asked of academic health centers. What do the healthcare system and the larger society require from academic health centers, and what are the most effective ways to meet these needs? At the crux of the answers to these questions cannot simply be the need to ensure the survival of academic health centers as we know them.[7] If survival is the most significant driver, it is doubtful that academic health centers will create a sustainable future for themselves, for the organizations that advance them, or for the communities that they serve.

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References

1 Van de Werf M. Changing economics of health care are devastating academic medical centers. Chronicle of Higher Education 1999; XLV:A38-A39.
2 O'Neil E. Transformation of academic health in the US. West J Med 1998;168:355-359.
3 Epstein A. US teaching hospitals in the evolving health care system. JAMA 1995;273:1203-1207.
4 Blumenthal D, Meyer G. The future of the academic health center under health care reform. N Engl J Med 1993;329:1812-1814.
5 AAMC STAT (Association of American Medical Colleges Short, Topical, And Timely News) June 28, 1999.
6 URL: http://www.drexel.edu/univrel/dxlink/nov98/.
7 O'Neil E. Health professions education for the future: schools in service to the nation. San Francisco (CA): Pew Health Professions Commission; 1993.

One hundred years ago

In an excerpt from the Transactions of the Medical Society of California, 1898, J.W. Robertson wrote:

Of all sexual conditions complicating insanity, none occupy the importance either in the professional or lay mind that masturbation holds. It is a vice of most frequent occurrence amongst our sane population, and it is almost universally practiced by the insane. That masturbation alone, in the normal individual, produces insanity is certainly not true; for were this the case, the accommodations of our asylums would have to be so increased as to hold at least 500,000 rather than the 5,000 insane credited to our State.